

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029901

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7780

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 3400 South Grand	
3. NAME OF DECEASED (Type or print) First OTILLIA Middle ELLI Last		4. DATE OF DEATH Month 7 Day 28 Year 63	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (City and state or country) St. Louis	
13a. FATHER'S NAME John Elli		13b. MOTHER'S MAIDEN NAME Beckley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of serv) NO		17. INFORMANT Address Joseph Elli 4246 Dewey	
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 491x DUE TO (c)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 7 a.m. 19 p.m. 63		20f. CITY, TOWN, OR LOCATION 7 28 63	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 9:00 PM to 7 28 63 and last saw her alive on 7 28 63 Death occurred at 9:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS 1515 LAFAYETTE AVE.	
22a. SIGNATURE O. P. Stein MD		22c. DATE SIGNED 7 28 63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial, Removal		23b. DATE 7/31/63	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cath. Cem.		23d. LOCATION (City, town, or county) (State) Lemay, Mo.	
24. FUNERAL DIRECTOR Wingbermuehle Funeral Home		25. DATE RECD. BY LOCAL REG. JUL 30 1963	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.			

STEIN'S
USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

G. J. Dougherty

Licensed Embalmer No. 4611

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.